Exhibit 3(n): Watson

- J1094
- J1100
- J3360
- J2916
- J1580
- J1750
- J3370

[redacted] Employee

04-2755996

57

REDACTED

06/04/2004
Date Issued

Amount Paid: $11.34

PEABODY, MA 01960

REDACTED

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. 2538464

Check No. 1082600

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Par Charge Covered	Covered Allowed	Mail Med Paid	Mail Med Paid
04/26/2004	04/26/2004	$380.00	$0.00	$11.34	$11.34	$11.34

[redacted]

Comments:

CHARGES APPLIED TO YOUR MEDICARE PART B DEDUCTIBLE ARE NOT PAYABLE UNDER THIS PLAN. $100.00 WAS APPLIED TO DED

REDACTED

[redacted]

ELIOT G SHERR DPM
205 ANDOVER ST
PEABODY, MA 01960

Provider: ELIOT G SHERR DPM
Participant SSN:
RES .Claim Number: 2538464

Processed by *Southern Benefit Administrators, Inc.*

APPROVED OMB-0938-0008

SMW+
SHEET METAL WORKERS NATL HEALTH
PO BOX 1449
GOODLETTSVILE, TN 37070-1449

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE: 08 23 1922 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: PEABODY STATE: MA

ZIP CODE: 01960 TELEPHONE (Include Area Code)

8. PATIENT STATUS: Single X Married Other

CITY: PEABODY STATE: MA

ZIP CODE: 01960 TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO

b. INSURED'S DATE OF BIRTH: 08 23 1922 SEX: M X F

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M X F

b. AUTO ACCIDENT? YES X NO PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

d. INSURANCE PLAN NAME OR PROGRAM NAME: SMW+

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on file DATE 05 25 2004

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on file

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 04 26 2004

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: SHERR, ELIOT G.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: T11304

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 355.6
2. 727.00
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 26 2004		11	01	99203	25	12	165 00					
2 04 26 2004		11	02	20600		12	135 00					
3 04 26 2004		11	01	10704		12	40 00					
4 04 26 2004		11	01	11094		12	40 00					
5 04 26 2004		11	01	20000		12	20 00					
6 04 26 2004		11	01	S0020		12	20 00					

25. FEDERAL TAX I.D. NUMBER: 042755996 SSN EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 420 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 420 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ELIOT G SHERR DPM

SIGNED 05 25 2004 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

NORTH SHORE PODIATRY
205 ANDOVER STREET
PEABODY, MA 01960

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ELIOT G SHERR DPM
205 ANDOVER STREET
PEABODY, MA 01960

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) WHCFA-1500-1-N-90 (5/02)

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

REDACTED

HERITAGE INSURANCE COMPANY — MEDICARE REMITTANCE NOTICE

PROV: Y70620 — 127545140 — 05/17/04 — ELIOT G. SHERR DPM — PAGE #: 3 OF 14

PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]									ICN 0204125004050	ASG Y	MOA MA01 MA18
Y70620	0329 032904 11		1	99213	25	95.00	55.97	0.00	11.19 CO-42	39.03	44.78
Y70620	0329 032904 11		1	10061		250.00	173.10	0.00	34.62 CO-42	74.90	138.48
PT RESP	45.81			CLAIM TOTALS		345.00	229.07	0.00	45.81	113.93	183.26
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											183.26 NET
[redacted]									ICN 0204125004300	ASG Y	MOA MA01 MA18
Y70620	0429 042904 11		1	99213		95.00	55.97	0.00	11.19 CO-42	39.03	44.78
PT RESP	11.19			CLAIM TOTALS		95.00	55.97	0.00	11.19	39.03	44.78
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											44.78 NET
[redacted]									ICN 0204125004110	ASG Y	MOA MA01 MA18
Y70620	0421 042104 11		1	99213		95.00	55.97	0.00	11.19 CO-42	39.03	44.78
PT RESP	11.19			CLAIM TOTALS		95.00	55.97	0.00	11.19	39.03	44.78
											44.78 NET
[redacted]									ICN 0204125004320	ASG Y	MOA MA01 MA18
Y70620	0429 042904 11		1	99203		165.00	101.16	0.00	20.23 CO-42	63.84	80.93
Y70620	0429 042904 11		1	73620	RT	95.00	29.70	0.00	5.94 CO-42	65.30	23.76
Y70620	0429 042904 11		1	73620	LT	95.00	29.70	0.00	5.94 CO-42	65.30	23.76
PT RESP	32.11			CLAIM TOTALS		355.00	160.56	0.00	32.11	194.44	128.45
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											128.45 NET
[redacted]									ICN 0204125004140	ASG Y	MOA MA01 MA18
Y70620	0422 042204 11		1	99213		95.00	55.97	0.00	11.19 CO-42	39.03	44.78
PT RESP	11.19			CLAIM TOTALS		95.00	55.97	0.00	11.19	39.03	44.78
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											44.78 NET
[redacted]									ICN 0204125004170	ASG Y	MOA MA01 MA18
Y70620	0422 042204 11		1	99203		165.00	101.16	0.00	20.23 CO-42	63.84	80.93
PT RESP	20.23			CLAIM TOTALS		165.00	101.16	0.00	20.23	63.84	80.93
											80.93 NET
[redacted]									ICN 0204125004120	ASG Y	MOA MA01 MA18
Y70620	0422 042204 11		1	99213	25	95.00	55.97	0.00	11.19 CO-42	39.03	44.78
Y70620	0422 042204 11		1	29540		75.00	38.01	0.00	7.60 CO-42	36.99	30.41
PT RESP	18.79			CLAIM TOTALS		170.00	93.98	0.00	18.79	76.02	75.19
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											75.19 NET
NAM											DA MA01 MA15
Y70620	0426 042604 11		1	99203	25	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0.93
Y70620	0426 042604 11		1	20600		135.00	53.97	0.00	10.79 CO-42	81.03	43.18
Y70620	0426 042604 11		1	J0704		40.00	0.96	0.00	0.19 CO-42	39.04	0.77
Y70620	0426 042604 11		1	J1094		40.00	1.64	0.00	0.13 CO-42	39.36	0.51
PT RESP	111.34			CLAIM TOTALS		380.00	156.73	0.00	11.34	223.27	45.39
											45.39 NET
NAME [redacted]									ICN 0204125004200	ASG Y	MOA MA01 MA18
Y70620	0426 042604 11		1	99213	25	95.00	55.97	0.00	11.19 CO-42	39.03	44.78
Y70620	0426 042604 11		1	11721		60.00	39.99	0.00	8.00 CO-42	20.01	31.99
Y70620	0426 042604 11		1	20600	RT59	135.00	53.97	0.00	10.79 CO-42	81.03	43.18
Y70620	0426 042604 11		1	20600	LT5951	135.00	26.99	0.00	5.40 CO-42	81.03	21.59
									CO-59	26.98	
Y70620	0426 042604 11		2	J0704		80.00	1.92	0.00	0.38 CO-42	78.08	1.54
Y70620	0426 042604 11		2	J1094		80.00	1.28	0.00	0.26 CO-42	78.72	1.02
PT RESP	36.02			CLAIM TOTALS		585.00	180.12	0.00	36.02	404.88	144.10
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											144.10 NET
[redacted]									ICN 0204125004290	ASG Y	MOA MA01 MA18
Y70620	0428 042804 11		1	99213	25	95.00	55.97	4.04	10.39 CO-42	39.03	41.54
Y70620	0428 042804 11		1	11721		60.00	39.99	0.00	8.00 CO-42	20.01	31.99
PT RESP	22.43			CLAIM TOTALS		155.00	95.96	4.04	18.39	59.04	73.53
											73.53 NET
[redacted]									ICN 0204125004090	ASG Y	MOA MA01 MA18
Y70620	0421 042104 11		1	99213		95.00	55.97	0.00	11.19 CO-42	39.03	44.78
PT RESP	11.19			CLAIM TOTALS		95.00	55.97	0.00	11.19	39.03	44.78
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											44.78 NET
[redacted]									ICN 0204125004160	ASG Y	MOA MA01 MA18
Y70620	0422 042204 11		1	99203	25	165.00	101.16	0.00	20.23 CO-42	63.84	80.93
Y70620	0422 042204 11		1	11720		60.00	27.00	0.00	5.40 CO-42	33.00	21.60
PT RESP	25.63			CLAIM TOTALS		225.00	128.16	0.00	25.63	96.84	102.53
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											102.53 NET

REDACTED

REDACTED Employee
04-3296910

12/01/2001
Date Issued

REDACTED

Amount Paid: $40.95

HANOVER, MA 02339

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **1618975**

Check No. **0142626**

Explanation of Benefits

SMW+ Program

Dates of Service From	To	Amount Charged	Non-Covered	Charges Allowed	Ded/Coins	Met Med Paid
10/09/2001	10/09/2001	$309.00	$0.00	$40.95	$40.95	$40.95

Comments:

Provider: COMMONWEALTH HEMATOLOGY ON
Participant SSN:
DMA Claim Number: 1618975

COMMONWEALTH HEMATOLOGY O
10 WILLARD ST
QUINCY, MA 02169

Processed by *Southern Benefit Administrators, Inc.*

REDACTED

IN THIS AREA GOODLETTSVILLE TN 37070

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER — 1a. [redacted]

2. PATIENT'S NAME — [redacted]

3. PATIENT'S BIRTH DATE 12 04 1935 — SEX M [X] F [ ]

4. INSURED'S NAME — [redacted]

5. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

6. PATIENT'S ADDRESS: CITY HANOVER — STATE MA — ZIP CODE 02339

7. INSURED'S ADDRESS: CITY — STATE — ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )

8. PATIENT STATUS: Single [ ] Married [ ] Other [X] — Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME — [redacted]

a. OTHER INSURED'S DATE OF BIRTH — SEX M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO — If yes, return to and complete item 9 a-d.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO

b. AUTO ACCIDENT? [ ] YES [X] NO — PLACE (State)

c. OTHER ACCIDENT? [ ] YES [X] NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH — SEX M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME — [redacted]

c. INSURANCE PLAN NAME OR PROGRAM NAME: SHEET METAL WKRS HLTH FD

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE — DATE 11/09/01

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) — MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — MM DD YY FROM — TO — MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JAMES R EVERETT MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — MM DD YY FROM — TO — MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [X] NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 162.9 NEOPLASM LUNG
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 09 01		3	90	J7050		1	40 00	4				
2 10 09 01		3	90	J1260		1	230 00	10				
3 10 09 01		3	90	J1200		1	4 00	2				
4 10 09 01		3	90	J1100		1	18 00	3				
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN EIN — 04-3296910 [X]

26. PATIENT'S ACCOUNT NO. — [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ 292 00

29. AMOUNT PAID $ 251 05

30. BALANCE DUE $ 40 95

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JAMES EVERETT, M.D.

SIGNED 11/09/01 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

COMMONWEALTH HEM-ONC
10 WILLARD STREET
QUINCY MA 02169

PIN# — GRP#

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

SECOND INSURANCE

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20160
CHECK/EFT #:125170270 10/29/01

125170270 100002167
COMMONWEALTH HEMATOLOGY
PAGE #: 3 OF 10

MEDICARE REMITTANCE NOTICE

REDACTED

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME							ICN 020128915440O ASG			Y MOA MA01	
J23017	1009 100901 11		4	J7050		40.00	36.36	0.00	7.27 CO-42	3.64	29.09
J23017	1009 100901 11		10	J1260		230.00	164.50	0.00	32.90 CO-42	65.50	131.60
J23017	1009 100901 11		2	J1200		4.00	1.02	0.00	0.20 CO-42	2.98	0.82
J23017	1009 100901 11		3	J1100		18.00	2.91	0.00	0.58 CO-42	15.09	2.33
J23017	1009 100901 11		1	85024		17.00	11.70	0.00	0.00 CO-42	5.30	11.70
PT RESP	40.95			CLAIM TOTALS		309.00	216.49	0.00	40.95	92.51	175.54
											175.54 NET

NAME											MA18
J12474	0927 092701 22		1	99214		114.00	59.38	0.00	11.88 CO-B6	54.62	47.50
PT RESP	11.88			CLAIM TOTALS		114.00	59.38	0.00	11.88	54.62	47.50
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											47.50 NET

NAME											
J09389	1010 101001 11		1	85024		17.00	11.70	0.00	0.00 CO-42	5.30	11.70
PT RESP	0.00			CLAIM TOTALS		17.00	11.70	0.00	0.00	5.30	11.70
											11.70 NET

NAME											
J09389	1010 101001 11		1	99214		114.00	87.78	0.00	17.56 CO-42	26.22	70.22
J09389	1010 101001 11		1	96410		93.00	74.70	0.00	14.94 CO-42	18.30	59.76
J09389	1010 101001 11		2	96412		166.00	110.62	0.00	22.12 CO-42	55.38	88.50
J09389	1010 101001 11		6	J9310		3732.00	2727.30	0.00	545.46 CO-42	1004.70	2181.84
J09389	1010 101001 11		1	J1200		2.00	0.51	0.00	0.10 CO-42	1.49	0.41
PT RESP	600.18			CLAIM TOTALS		4107.00	3000.91	0.00	600.18	1106.09	2400.73
CLAIM INFORMATION FORWARDED TO: EMPIRE BC/BS											2400.73 NET

NAME									ASG	Y MOA MA01	
J09389	1010 101001 11		1	G0001		10.00	3.00	0.00	0.00 CO-42	7.00	3.00
PT RESP	0.00			CLAIM TOTALS		10.00	3.00	0.00	0.00	7.00	3.00
											3.00 NET

NAME											
J02033	1011 101101 11		1	99213		73.00	56.41	0.00	11.28 CO-42	16.59	45.13
J02033	1011 101101 11		1	85023		20.00	11.71	0.00	0.00 CO-42	8.29	11.71
J02033	1011 101101 11		1	60001		10.00	3.00	0.00	0.00 CO-42	7.00	3.00
PT RESP	11.28			CLAIM TOTALS		103.00	71.12	0.00	11.28	31.88	59.84
											59.84 NET

NAME											
J05964	0917 091701 32		1	99312		76.00	57.89	0.00	11.58 CO-42	18.11	46.31
J05964	0918 091801 32		1	99311		46.00	36.09	0.00	7.22 CO-42	9.91	28.87
PT RESP	18.80			CLAIM TOTALS		122.00	93.98	0.00	18.80	28.02	75.18
											75.18 NET

NAME											
J23017	1009 100901 11		1	99214		114.00	87.78	0.00	17.56 CO-42	26.22	70.22
J23017	1009 100901 11		1	90782		7.00	0.00	0.00	0.00 CO-B15	7.00	0.00
PT RESP	17.56			CLAIM TOTALS		121.00	87.78	0.00	17.56	33.22	70.22
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											70.22 NET

NAME											
J23017	1009 100901 11		1	85024		17.00	11.70	0.00	0.00 CO-42	5.30	11.70
J23017	1009 100901 11		1	60001		10.00	3.00	0.00	0.00 CO-42	7.00	3.00
J23017	1009 100901 11		30	00136		468.00	367.80	0.00	73.56 CO-42	100.20	294.24
PT RESP	73.56			CLAIM TOTALS		495.00	382.50	0.00	73.56	112.50	308.94
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											308.94 NET

NAME											
										MA18	
J23017	0925 092501 11		1	J3490 CC		10.00	3.15	0.00	0.63 CO-42	6.85	2.52
PT RESP	0.63			CLAIM TOTALS		10.00	3.15	0.00	0.63	6.85	2.52
CLAIM INFORMATION FORWARDED TO: METLIFE INS. CO											2.52 NET

NAME											
B49039	0929 092901 21		1	99254		210.00	160.85	0.00	32.17 CO-42	49.15	128.68
B49039	0930 093001 21		1	99231		50.00	39.08	0.00	7.82 CO-42	10.92	31.26
PT RESP	39.99			CLAIM TOTALS		260.00	199.93	0.00	39.99	60.07	159.94
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											159.94 NET

NAME											
A28399	0921 092101 22		1	99214		114.00	59.38	0.00	11.88 CO-B6	54.62	47.50
PT RESP	11.88			CLAIM TOTALS		114.00	59.38	0.00	11.88	54.62	47.50
											47.50 NET

EMPLOYER	DEPENDENT (IF APPLICABLE)	RELATIONSHIP
REDACTED		E
PROVIDER TAX I.D. #:	PATIENT ACCOUNT #	10
	38084372	

87-4
640

NO 0532886

10/23/2002
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY *******225DOLLARS AND 49CENTS** DOLLARS $ ****225.49**

TO THE ORDER OF

0532886

WINCHESTER HOSPITAL
41 HIGHLAND AVE
WINCHESTER , MA 01890

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, Nashville
Nashville, Tennessee 37279

⑈00532886⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
09/12/2002	09/12/2002	1305.18	.00	225.49	225.49	225.49
		1305.18	.00	225.49	225.49	225.49

NON-COVERED CODES:

COMMENTS:

REDACTED REDACTED

PROVIDER: WINCHESTER HOSPITAL
PARTICIPANT DEPEND :01
CLD CLAIM NUMBER: 1948453

LEXINGTON MA 02173

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

APPROVED OMB NO. 0938-0279

WINCHESTER HOSPITAL
41 HIGHLAND AVE
WINCHESTER, MA 01890
8[illegible]

3 PATIENT CONTROL NO.: 38084372 | 131

5 FED. TAX NO.: 042104434 | 4 TYPE OF BILL: 091202 | 6 STATEMENT COVERS PERIOD: 091202 | 7 COV'D. | 8 N-C'D. | 9 C-I'D. | 10 L-R'D. | 11

12 PATIENT NAME

13 PATIENT ADDRESS: LEXINGTON;MA;02173

14 BIRTHDATE	15 SEX	16 MS	17	18	19	20	21 D HR	22 STAT	23 MEDICAL RECORD NO.	31
10311939	M	M	091202	10	9	1	99	01	348328	

32 OCCURRENCE CODE | 33 OCCURRENCE | 34 OCCURRENCE | 35 OCCURRENCE SPAN CODE | FROM | THROUGH | 36 OCCURRENCE SPAN CODE | FROM | THROUGH | 37

38 SHEET METAL WORKERS NATIONAL
P.O.BOX 1449
GOODLETTSVILLE, TN 37070-1449

39 VALUE CODES: A2 22549

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	PHARMACY	J2175	091202	2	194		
2								
3	260	INTRAVENOUS THERAPY	Q0081	091202	1	20000		
4								
5	490	AMBULATORY SURGERY	45378	091202	1	67650		
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	TOTAL CHARGE				130518		

50 PAYER	51 PROVIDER NO.	52 REL. BEN.	53 ASSIGN BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A MEDICARE PACIFIED	220105	Y	Y	107969		
B						
C						

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A		01		RETIRED	
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			RETIRED	
B				
C				

67 PRIN. DIAG. CD.	OTHER DIAG. CD.	OTHER DIAG. CD.	OTHER DIAG. CD.	OTHER DIAG. CD.	78 ADM. DIAG. CD.	77 E-CODE	78
56210	V1272						

76 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9	4523	091202	A		B	

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
C		D		E	

81 MA71339
F25208 MUGGIA,ROBERT A

82 MA71339 A
F25208 MUGGIA,ROBERT A
B

84 REMARKS

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SUMMARY PC-PRINT

220105 WINCHESTER HOSPITAL FYE: 09/30/02 PART A PAID DATE: 10/01/02 PAGE: 1

PATIENT NAME / HIC NUMBER / FROM DATE THRU DATE / CLAIM# CLM STATUS	F M / PATIENT CNTRL NUMBER / MEDICAL REC. NUMBER / ICN NUMBER / TOB NACHG HICHG	COST / NCV L / OUTCD / NCVDY / PAT ST / CV LN DRG #	DRG TOT AMT / DRG OPR AMT / DRG OUT AMT / DRG CAP AMT	REPTD CHGS / NCOVD CHGS / DENIED CHGS / COVD CHGS	MSP LIAB M / MSP PAYMT / DEDUCTIBLE / COINSUANCE	PROF COMP / PAT RESP / PAT REFUND / INTEREST	ESRD NET / REIMB RATE / ALLOWD AMT / G/R AMOUNT	CONT ADJ / PER DIEM / HCPCS AMT / NET REIMB
REM RC REM RC	REM RC REM RC	REM RC	RC RC					
	38084372 01 1	0 0	0.00	1305.18	0.00	0.00	0.00	814.83
	348328		0.00	0.00	0.00	225.49	0.00	0.00
09-12-02 09-12-02	1227322086	01	0.00	0.00	0.00	0.00	0.00	0.00
11 1	131 QC HN	0	0.00	1305.18	225.49	0.00	0.00	264.86

REDACTED

BERKSHIRE MEDICAL CENTER
PO BOX 4999
PITTSFIELD MA 01202
4130447211

2

3a PATIENT CONTROL M629907361

4 TYPE OF BILL 721

5 FED. TAX NO. 042791396 | 6 STATEMENT COVERS PERIOD FROM 010105 THROUGH 013105 | 7 COV'D | 8 H-C-D | 9 C-I-D | 10 L-R-D | 11

12 PATIENT NAME

13 PATIENT ADDRESS PITTSFIELD MA 01201

14 BIRTH DATE 02171920 | 15 SEX M | 16 MS M | 17 DATE 010105 | ADMISSION 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT 01 | 23 MEDICAL RECORD NO. M000065124 | CONDITION CODES 24 71 25 26 27 28 29 30 31

32 OCCURANCE CODE | DATE | 33 OCCURANCE CODE | DATE | 34 OCCURANCE CODE | DATE | 35 OCCURANCE DATE | 36 OCCURANCE SPAN FROM THROUGH

37 (a) 20505400740502 A; B; C

38 ~~MEDICARE A~~ B
~~PO BOX 1602~~

OMAHA NE 68103

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	49	47 80	68	22500 00		
b						
c						
d						

	42 REV. CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0304	ASSAY OF PARATHORMONE	83970	011305	1	180 41		
2	0304	BLOOD CULTURE FOR BACTE	8704091	010105	2	90 28		
3	0304	ASSAY FERRITIN	82728	011305	1	59 56		
4	0304	TRANSFERRIN	84466	011305	1	55 82		
5	0304	HEPATITIS B SURFACE ANT	86706	011305	1	45 70		
6	0304	INFECTIOUS AGENT ANTIGE	87340	011305	1	45 14		
7	0304	ASSAY, ALUMINUM	82108	011305	1	42 65		
8	0304	ASSAY OF GGT	82977CF	011305	1	31 48		
9	0304	ASSAY IRON	83540	011305	1	28 32		
10	0304	ASSAY TRIGLYCERIDES	84478CF	011305	1	25 16		
11	0304	ALANINE AMINO (ALT) (SG	84460CF	011305	1	23 17		
12	0304	ASSAY ALKALINE PHOSPHAT	84075CD	011305	1	22 62		
13	0304	TRANSFERASE (AST) (SGOT	84450CD	011305	1	22 57		
14	0304	ASSAY CALCIUM	82310CD	011305	1	22 52		
15	0304	ASSAY CREATININE	82565CD	011305	1	22 37		
16	0304	BILIRUBIN; TOT	82247CF	011305	1	21 93		
17	0304	ASSAY SERUM ALBUMIN	82040CD	011305	1	21 67		
18	0304	ASSAY BLOOD CARBON DIOX	82374CD	011305	1	21 37		
19	0304	ASSAY SERUM SODIUM	84295CF	011305	1	21 03		
20	0304	ASSAY PHOSPHORUS	84100CD	011305	1	20 75		
21	0304	ASSAY BLOOD CHLORIDE	82435CD	011305	1	20 09		
22	0304	ASSAY SERUM POTASSIUM	84132CD	011305	1	20 09		
23		Charge page 1 of 3						

	50 PAYER	51 PROVIDER NO.	52 REL	53 ASG	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	MEDICARE	222305	Y	Y	7885 99		
B	Sheet Metal Workers	04879 1396					
C							
57		DUE FROM PATIENT >>					

58 P. REL 18 | 59 61 GROUP NAME | 62 INSURANCE GROUP NO.

R NAME | PLACE OF SERVICE LOCATION

[redacted]

67 PRINC. DIAG.	68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
585	10391	2859	28521	7806	2809	5889	2753	2724			

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9						

82 ATTENDING PHYS ID 24 042791396
B98024 ROSE HENRY
83 OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE ELLIE QUINLAN
86 DATE 022305

08-92 HCFA-1450

BERKSHIRE MEDICAL CENTER
PO BOX 4999
PITTSFIELD MA 01202
4130447211

2

3 PATIENT CONTROL NO. M629907361

4 TYPE OF BILL 721

5 FED. TAX NO. 042791396 | 6 STATEMENT COVERS PERIOD FROM 010105 THROUGH 013105 | 7 COV D. | 8 N-C-D | 9 C-I-D. | 10 L-R-D | 11

12 PATIENT NAME

13 PATIENT ADDRESS [redacted] PITTSFIELD MA 01201

14 BIRTH DATE [redacted] | 15 SEX M | 16 DATE | 17 STAT | 18 ADMISSION HOUR | 19 TYPE 1 | 20 SRC | 21 D HR | 22 STAT 01 | 23 MEDICAL RECORD NO. M000065124 | 24 | CONDITION CODES 25 26 27 28 29 30 | 31

32 OCCURANCE CODE / DATE | 33 OCCURANCE CODE / DATE | 34 OCCURANCE CODE / DATE | 35 OCCURANCE CODE / DATE | 36 OCCURANCE SPAN FROM / THROUGH

a
b

A 20505400740502
B
C

38 MEDICARE A B
PO BOX 1602

OMAHA NE 68103

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	49	47 80	68	22500 00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0304	ASSAY SERUM CHOLESTEROL	82465CF	011305	1	19 03		1
2	0304	ASSAY UREA NITROGEN	84520CD	011305	1	17 23		2
3	0304	ASSAY UREA NITROGEN	84520CD91	011305	1	17 23		3
4	0304	ASSAY QUANTITATIVE, GLU	82947CF	011305	1	17 14		4
5	0304	ASSAY PROTEIN	84155CD	011305	1	16 01		5
6	0634	INJECTION EPOETIN ALFA	Q4055	010105	1	234 69		6
7	0634	INJECTION EPOETIN ALFA	Q4055	010405	1	156 46		7
8	0634	INJECTION EPOETIN ALFA	Q4055	010805	1	156 46		8
9	0634	INJECTION EPOETIN ALFA	Q4055	011105	1	156 46		9
10	0634	INJECTION EPOETIN ALFA	Q4055	011305	1	156 46		10
11	0634	INJECTION EPOETIN ALFA	Q4055	011505	1	156 46		11
12	0634	INJECTION EPOETIN ALFA	Q4055	010605	1	156 46		12
13	0636	SODIUM FERRIC GLUCONATE	J2916	011305	10	244 53		13
14	0636	SODIUM FERRIC GLUCONATE	J2916	012005	10	244 53		14
15	0821	DIALYSIS PROCEDURE	90999G5	010405	1	445 55		15
16	0821	DIALYSIS PROCEDURE	90999G5	010605	1	445 55		16
17	0821	DIALYSIS PROCEDURE	90999G5	010805	1	445 55		17
18	0821	DIALYSIS PROCEDURE	90999G5	011105	1	445 55		18
19	0821	DIALYSIS PROCEDURE	90999G3	011305	1	445 55		19
20	0821	DIALYSIS PROCEDURE	90999G3	011505	1	445 55		20
21	0821	DIALYSIS PROCEDURE	90999G3	011805	1	445 55		21
22	0821	DIALYSIS PROCEDURE	90999G3	012005	1	445 55		22
23		Charge page 2 of 3						23

	50 PAYER	51 PROVIDER NO.	52 REL	53 ASG	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	MEDICARE	222305	Y	Y	7885 99		
B							
C							

57 DUE FROM PATIENT >>

	58 INSURED'S NAME	P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A		18	[redacted]		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	[redacted]	5		
B				
C				

67 PRIN. DIAG. CD	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
585	40391	2859	28521	7806	2809	5889	2753	2724			

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
9				

82 ATTENDING PHYS ID 24 042791396
B98024 ROSE HENRY
83 OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE ELLIE QUINLAN
86 DATE 022305

UB-92 HCFA-1450

BERKSHIRE MEDICAL CENTER
PO BOX 4999
PITTSFIELD MA 01202
4130447211

2 | 3a PATIENT CONTROL M629907361 | 4 TYPE OF BILL 721

5 FED. TAX NO. 042791396 | 6 STATEMENT COVERS PERIOD FROM 010105 THROUGH 013105 | 7 COV D | 8 N-C-D | 9 C-I-D | 10 I-R-I | 11

12 PATIENT NAME [redacted] | 13 PATIENT ADDRESS [redacted] PITTSFIELD MA 01201

14 BIRTH DATE	15 SEX	16 DHR	17 STAT	18 ADMISSION TYPE	19 SRC	20 DHR	22 STAT	23 MEDICAL RECORD NO.	24 25 26 27 28 29 30 CONDITION CODES	31
02171920	M	M	010105	09	31	1	01	M000065124	71	

32 OCCURANCE CODE	DATE	33 OCCURANCE CODE	DATE	34 OCCURANCE CODE	DATE	35 OCCURANCE CODE	DATE	36 OCCURANCE SPAN FROM	THROUGH	37 A	20505400740502
a										B	
b										C	

38 MEDICARE A B
PO BOX 1602

OMAHA NE 68103

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	49	47 80	68	22500 00		
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0821	DIALYSIS PROCEDURE	90999G3	012205	1	445 55		
2	0821	DIALYSIS PROCEDURE	90999G3	012505	1	445 55		
3	0821	DIALYSIS PROCEDURE	90999G3	012705	1	445 55		
4	0821	DIALYSIS PROCEDURE	90999G3	012905	1	445 55		
5	0821	DIALYSIS PROCEDURE	90999G5	010105	1	445 55		
6		Charge page 3 of 3						
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	0001	TOTAL CHARGES				8406 00		

	50 PAYER	51 PROVIDER NO.	52 REL	53 ASG	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	MEDICARE	222305	Y	Y	7885 99		
B							
C							

57 DUE FROM PATIENT >>

	58 INSURED'S NAME	59 P REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	[redacted]	18	[redacted]		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A		5		
B				
C				

OTHER DIAG. CODES

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
585	40391	2859	28521	7806	2809	5889	2753	2724			

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 CODE	OTHER PROCEDURE DATE	CODE	OTHER PROCEDURE DATE
9						

82 ATTENDING PHYS ID 24 042791396
B98024 ROSE HENRY
83 OTHER PHYS. ID

84 REMARKS

85 PROVIDER REPRESENTATIVE ELLIE QUINLAN
86 DATE 022305

UB-92 HCFA-1450

MEDICARE INTERMEDIARY REMITTANCE ADVICE

BERKSHIRE MEDICAL CENTER
PO BOX 4999
PITTSFIELD MA 012020000

FISCAL PERIOD ENDING / /
BILL TYPE 721

MEDICARE
MUTUAL OF OMAHA
PO BOX 2350
OMAHA NE 681030000

INTERMEDIARY FILE DATE 04/21/05 PRINT DATE 05/12/05 PROVIDER NO. 222305

PCN M629907361 SERVICE FROM 01/01/05 THRU 01/31/05
ICN 20505400740502 PAT STAT CLM STAT

MRN [redacted] CLM

REDACTED

CHARGES:	PAYMENT DATA: =DRG	0.00=REIM RATE
8406.00=REPORTED	0.00=DRG AMOUNT	0.00=MSP PRIM PAYER
0.00=NCVD	0.00=DRG OPER	0.00=PROF COMPONENT
0.00=DENIED	0.00=HCPCS AMOUNT	0.00=ESRD AMOUNT
5913.34=CLAIM ADJS	0.00=OUTLIER	0.00=PROC CD AMOUNT
8406.00=COVERED	0.00=CAP OUTLIER	0.00=ALLOW\REIM
DAYS/VISITS:	0.00=CASH DEDUCT	0.00=G/R AMOUNT
0=COST REPT	0.00=BLOOD DEDUCT	0.00=INTEREST
0=COVD/UTIL	520.01=COINSURANCE	5913.34=CONTRACT ADJ
0=NON-COVERED	0.00=PAT REFUND	0.00=PER DIEM AMT
0=COVD VISITS	0.00=MSP LIAB MET	1972.65=NET REIM AMT
0=NCOV VISITS		

ADJ REASON CODES:

PAGE 1 of 1

REDACTED

	Employee
04-3477239	F207550883

20

REDACTED

06/22/2004
Date Issued

Amount Paid: $411.04

SO WEYMOUTH, MA 02190

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **2554958**

Check No. **1098039**

Explanation of Benefits **SMW+ Program**

Dates of Service From	To	Amount Charged	Non-Covered	Covered Allowed	Med/Med Pd/To Med	Paid
01/07/2004	01/08/2004	$3,510.55	$0.00	$411.04	$411.04	$411.04
[redacted]						

Comments:

REDACTED

Provider: QUINCY MEDICAL CENTER
Participant SSN: Dependent: 01
VLC Claim Number: 2554958

[redacted]
QUINCY MEDICAL CENTER
114 WHITWELL STREET
QUINCY, MA 02169

Processed by *Southern Benefit Administrators, Inc.*

APPROVED OMB NO. 0938-0277

QUINCY MEDICAL CENTER
114 WHITWELL STREET
QUINCY MA 02169

REPLACED

3 PATIENT CONTROL NO.	4 TYPE OF BILL
FZ0755088 3	831

5a FED. TAX NO.	6 STATEMENT COVERS PERIOD		7 COV'D.	8 N-C'D.	9 C-I'D.	10 L-R'D.	11
04-3477239	010704	010804	1	0			

12 PATIENT NAME

13 PATIENT ADDRESS ;SOUTH WEYMOUTH;MA;02190

14 BIRTHDATE	15 SEX	16 MS	17	18	19	20	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30	31
07221923	M	W	010704	08	3	1	14	01	M0095106		

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE SPAN CODE	34 OCCURRENCE SPAN FROM	34 OCCURRENCE SPAN THROUGH
a							
b							

35 VALUE CODES

	36 CODE	AMOUNT
a		
b		
c		
d		

37 A B C

38 SHEET METAL WORKERS NATIONAL
HEALTH FUND
PO BOX 1449
GOODLETTSVILLE, TN 37070-1449

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	PHARMACY			11	10409		
2								
3	300	LABORATORY	86850	010204	1	6512		
4								
5	305	LABORATORY HEMATOLOGY	85027		1	2230		
6								
7	370	ANESTHESIA			1	46345		
8								
9	636	DRUGS REQUIRING DETAIL	J1580		1	210		
10								
11	730	EKG / ECG	93005		1	6289		
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23	001	TOTAL CHARGE				353590	0	

	50 PAYER	51 PROVIDER NO.	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	MEDICARE REPLACED	220067	Y	Y	164599	0	
B							
C							

DUE FROM PATIENT 0

	57	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A			0			
B						
C						

	63 TREATMENT AUTHORIZATION CODES	64 ES	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A		5	RETIRED	
B				
C				

67 PRIN. DIAG. CD.			68	69	70	71 PPS CODE	72 ECI	73	74	75 ADM. DIAG. CD.	77 E-CODE	78
60000	75261	5963										

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	A	DATE	B	DATE
9	6029	010704				

C		D		E	

81 CC	a	b	c	d
	B97746	KALELI, ADNAN	MA53276	

82	a	b	c	d
	B97746	KALELI, ADNAN	MA53276	

84 REMARKS

MEDICARE EOP ATTACHED

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

220067 |QUINCY MEDICAL CENTER|09/30/2004| | 20040518 PAGE 26

PATIENT NAME	PATIENT CNTRL NUMBER	SRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM #/CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS		MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
	F20755088 3	040102	0	3510.55	000	1.55	0.370	1644.44	0.00
20412501196102		040108	0	0.00	0.00	0.00	0.00	20.87	0.00
266 |1	M0095106			-1.55	0.00	411.04	0.00	1455.07	-0.37
NAME CHG=QC	HIC CHG=RN TOB=131		0	0	3510.55		0.00	0.00	0.00	1645.99

2nd

REDACTED

APPLICABLE) | RELATIONSHIP
E

87-4
540
M

PROVIDER TAX I.D. #: 222519813

REDACTED

PATIENT ACCOUNT # REDACTED 40.

NO 0501566

09/20/2002
DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY ********62DOLLARS AND 80CENTS** DOLLARS $*****62.80**

TO THE ORDER OF
WING MEMORIAL HOSPITAL CORP.
40 WRIGHT ST.
PALMER , MA 01069

0501566

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

SunTrust Bank, Nashville
Nashville, Tennessee 37230

⑈0050155⑈ ⑆064000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
07/10/2002	07/10/2002	801.36	.00	62.80	62.80	62.80
		801.36	.00	62.80	62.80	62.80

NON-COVERED CODES:

COMMENTS:

PROVIDER: WING MEMORIAL HOSPITAL CORP.
PARTICIPANT SSN: 014-05-3319 DEPENDENT: HOWARD :01
SOS CLAIM NUMBER: 1915854

REDACTED

WILBRAHAM MA 01095

Processed by SOUTHERN BENEFIT ADMINISTRATORS INC

APPROVED OMB NO. 0938-0279

WING MEMORIAL HOSPITAL
40 WRIGHT STREET
PALMER MA 01069
(413)283-7651

2 OP MCR 2NDRY

3 PATIENT CONTROL NO. V14329320 1 — TYPE OF BILL 131

5 FED. TAX NO. 222519813 — 6 STATEMENT COVERS PERIOD FROM 071002 THROUGH 071002 — 7 COV D. — 8 N-C D. — 9 C-H D. — 10 L-R D. — 11

REDACTED

WILBRAHAM MA 01095

14 BIRTHDATE 02091917 — 15 SEX M — 16 NS — ADMISSION DATE — HR — TYPE — SRC — 21 — 22 STAT — 23 MEDICAL RECORD NO. 01 M070591 — CONDITION CODES 09

a REDACTED
b

WILBRAHAM,MA 01095

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	636	RX DETAIL CODE	Q0136	071002	40	80136		
2								
3								
4								
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16								
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19								
20								
21								
22								
23	001	TOTAL CHARGE				80136		

A 50 PAYER: MEDICARE — 51 PROVIDER NO. 220030 — 52 REL INFO Y — 53 ASG BEN Y — 54 PRIOR PAYMENTS — 55 EST. AMOUNT DUE — 56
B SMW NATIONAL HEALTH
C

57 — DUE FROM PATIENT

A 58 INSURED'S NAME: REDACTED — 59 P REL 01 — 60 CERT. - SSN - HIC. - ID NO.: REDACTED — 61 GROUP NAME: MEDICARE — 62 INSURANCE GROUP NO.: MEDICAL WO 1022/SMW MED SU
B
C

A 63 TREATMENT AUTHORIZATION CODES — 64 ESC 5 — 65 EMPLOYER NAME — 66 EMPLOYER LOCATION
B
C

67 PRIN. DIAG. CD. 28529 — OTHER DIAG. CODES — 76 ADM. DIAG. CD. — 77 E-CODE — 78

79 P.C. 9 — 80 PRINCIPAL PROCEDURE CODE DATE — OTHER PROCEDURE CODE DATE — OTHER PROCEDURE CODE DATE — OTHER PROCEDURE CODE DATE — OTHER PROCEDURE CODE DATE — OTHER PROCEDURE CODE DATE

a 84 REMARKS
b
c
d

82 ATTENDING PHYS. ID D16778 SCHOONOVER LINDA MD
83 OTHER PHYS. ID
OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE CHRISTINE REGAN — 86 DATE 071002

UB-92 HCFA-1450 — OCR/Original

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

TUAL OF OMAHA MEDICARE
01 FARNAM STREET
AHA, NEBRASKA 68131

LE2042.MBX
0030 WING MEMORIAL HOSPITAL — OUTPATIENT — PAID DATE: 07/26/02 — RA # 000002184 — PAGE: 52

TIENT NAME / C NUMBER / DM DT THRU DT / AIM STATUS IDE#	PATIENT CNTRL NUMBER / ICN NUMBER / NACHG HICHG TOB / COST COVD NCOVD	RC REM DRG# / RC REM OUTCD CAPCD / RC REM PROF COMP / RC REM DRG OPR AMT	DRG OUT AMT / DRG CAP AMT / MSP PAYMT / DEDUCTIBLE	COINSURANCE / COVD CHGS / NCOVD CHGS / DENIED CHGS	PAT REFUND / ESRD NET ADJ / INTEREST	CONTRACT ADJ / PER DIEM RATE / HCPC AMOUNT / NET REIMBURS
CONDARY INSURANCE: WELFARE 0336015472	V14318901 VAA38130		0.00	10.84	0.00	-30.56
[redacted]	1219322611		0.00	18.69	0.00	0.00
/09/02 07/09/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		38.41
CONDARY INSURANCE: MEDEX 8678648	V13852264 VAA38132		0.00	15.06	0.00	-22.49
[redacted]	1219322426		0.00	52.78	0.00	0.00
/08/02 07/08/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		60.21
CONDARY INSURANCE: GIC MCR SUPPLEMENTAL 026205918 CIC	V14056436 VAA38135		0.00	10.52	0.00	-26.10
[redacted]	1219322444		0.00	26.48	0.00	0.00
/08/02 07/08/02	131	0.00	0.00	0.00	0.00	0.00
1		0.00	0.00	0.00		42.06
CONDARY INSURANCE: OTHER MEDICARE SUPPL 014053319	V14295208 VAA38137		0.00	67.34	0.00	420.46
REDACTED	1219322303		0.00	821.36	0.00	0.00
/03/02 07/03/02	131	0.00	0.00	0.00	0.00	0.00
1		0.00	0.00	0.00		333.58
CONDARY INSURANCE: OTHER MEDICARE SUPPL 014053319	V14329320 VAA38138		0.00	62.80	0.00	423.15
REDACTED	1219322596		0.00	801.36	0.00	0.00
/10/02 07/10/02	131	0.00	0.00	0.00	0.00	0.00
1		0.00	0.00	0.00		315.41
CONDARY INSURANCE: WELFARE 0165245806	V13993589 VAA38142		0.00	15.28	0.00	-18.05
[redacted]	1219322615		0.00	58.33	0.00	0.00
/09/02 07/09/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		61.10
ICONDARY INSURANCE: WELFARE 0290361141	V14309652 VAA38144		0.00	9.63	0.00	-26.34
[redacted]	1219322628		0.00	21.81	0.00	0.00
/09/02 07/09/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		38.52

APPROVED OMB NO. 0938-0279

WING MEMORIAL HOSPITAL
40 WRIGHT STREET
PALMER MA 01069
(413)283-7651

2 OP MCRSUPP (P)

3 PATIENT CONTROL NO. V14373724 1

131

5 FED. TAX NO. 222519813 | 6 STATEMENT COVERS PERIOD FROM 071702 THROUGH 071702 | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D.

REDACTED

WILBRAHAM MA 01095

14 BIRTHDATE 02091917 | 15 SEX M | 16 MS | 17 DATE | ADMISSION HOUR | 19 TYPE 1 | 20 SRC | 21 D HR | 22 STAT 01 | 23 MEDICAL RECORD NO. M070591

CONDITION CODES

32 OCCURRENCE CODE | OCCURRENCE DATE | 33 OCCURRENCE SPAN CODE | FROM | THROUGH | 34 OCCURRENCE CODE | OCCURRENCE DATE | 35 OCCURRENCE SPAN CODE | FROM | THROUGH | 36 OCCURRENCE CODE | OCCURRENCE SPAN FROM | THROUGH | 37

a REDACTED
b

VALUE CODES AMOUNT | VALUE CODES AMOUNT | VALUE CODES AMOUNT

WILBRAHAM,MA 01095

a
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 300	LABORATORY	G0001	071702	1	400		
2 305	LAB -HEMATOLOGY	B502	071702	1	4500		
3 305	LAB HEMATOLOGY	85610	071702	1	2200		
4 636	RX DETAIL CODE	Q0179	071702	20	80136		
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20							
21							
22					87236		
23	001 TOTAL CHARGE						

50 PAYER	51 PROVIDER NO.	52 REL. ASG. INFO	BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A MEDICARE	220030	Y	Y			
B SMW NATIONAL HEALTH		Y				
C						

DUE FROM PATIENT

57

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
REDACTED	01	REDACTED	MEDICARE SMW NATIONAL HEALTH WO	022/SMW MED SG
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	5		
B	5		
C			

67 PRIN. DIAG. CD. 28529 | 68 | OTHER DIAG. CODES | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE
		OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE

81 ATTENDING ID MA51739 SCHOONOVER LINDA MD

OPERATING ID

OTHER ID

a 84 REMARKS
b SMW NATIONAL HEALTH
c PO BOX 1449
d GOODLETTSVILLE, TN 37070-1449

85 PROVIDER REPRESENTATIVE GORDON STONE | 86 DATE 071702

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 OCR/Original

MUTUAL OF OMAHA MEDICARE
3201 FARNAM STREET
OMAHA, NEBRASKA 68131

FILE4512.MBX
220030 WING MEMORIAL HOSPITAL OUTPATIENT PAID DATE: 08/09/02 RA # 000002194 PAGE: 90

PATIENT NAME / HIC NUMBER / FROM DT THRU DT / CLAIM STATUS IDS#	PATIENT CNTRL NUMBER / ICN NUMBER / NACRG HICHG TOB / COST COVD NCOVD	RC REM DRG# / OUTCD CAPCD / PROF COMP / DRG OPR AMT	DRG OUT AMT / DRG CAP AMT / MSP PAYMT / DEDUCTIBLE	COINSURANCE / COVD CHGS / NCOVD CHGS / DENIED CHGS	PAT REFUND / BSRD NET ADJ / INTEREST	CONTRACT ADJ / PER DIEM RATE / RCPC AMOUNT / NET REIMBURS
SECONDARY INSURANCE: COMMERCIAL 014053319						
[redacted] A	V14252282 VAA39583		0.00	10.52	0.00	-5.80
[redacted]	1220718901		0.00	61.48	0.00	0.00
07/17/02 07/17/02	131	0.00	0.00	0.00	0.00	14.70
1		0.00	0.00	0.00		56.76
SECONDARY INSURANCE: OTHER MEDICARE SUPPL 014053319						
[redacted]	V14373724 VAA39584		0.00	62.80	0.00	474.01
[redacted]	1220718804		0.00	872.36	0.00	0.00
07/17/02 07/17/02	131	0.00	0.00	0.00	0.00	20.14
1		0.00	0.00	0.00		335.55
SECONDARY INSURANCE: OTHER MEDICARE SUPPL 014053319						
[redacted]	V14373724 VAA40204		0.00	4.54	0.00	-2.69
[redacted]	1220722624		0.00	20.80	0.00	0.00
07/17/02 07/17/02	131	0.00	0.00	0.00	0.00	0.00
1		0.00	0.00	0.00		18.15
SECONDARY INSURANCE: OTHER MEDICARE SUPPL 014053319						
[redacted]	V14403525 VAA40205		0.00	67.34	0.00	420.46
[redacted]	1220722734		0.00	821.36	0.00	0.00
07/22/02 07/22/02	131	0.00	0.00	0.00	0.00	0.00
1		0.00	0.00	0.00		333.56
SECONDARY INSURANCE: WELFARE 5047670791						
[redacted]	V14366694 VAA39585		0.00	23.12	0.00	13.70
[redacted]	1220718803		0.00	110.00	0.00	0.00
07/16/02 07/16/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		73.18
SECONDARY INSURANCE: BC OUT OF STATE MCR YLD094260948						
[redacted]	V14318349 VAA39586		0.00	631.44	0.00	142.17
[redacted]	1220718546		0.00	1550.15	0.00	0.00
07/15/02 07/15/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		776.54
SECONDARY INSURANCE: BC OUT OF STATE MCR YLA057263575						
[redacted]	V14280010 VAA39587		0.00	9.63	0.00	-26.34
[redacted]	1220719111		0.00	21.81	0.00	0.00
07/18/02 07/18/02	131	0.00	0.00	0.00	0.00	0.00
19		0.00	0.00	0.00		38.52

PROVIDER TAX I.D. #: 222519813

REDACTED

PLICABLE) | RELATIONSHIP: E

PATIENT ACCOUNT # REDACTED

87-4 640 M

NO 0501569

09/20/2002 DATE ISSUED

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. BOX 1449 • GOODLETTSVILLE, TN 37070-1449

PAY **********62DOLLARS AND 80CENTS** DOLLARS $ *****62.80**

TO THE ORDER OF

0501569

WING MEMORIAL HOSPITAL CORP.
40 WRIGHT ST.

PALMER , MA 01069

AUTHORIZED SIGNATURE

NON NEGOTIABLE

AUTHORIZED SIGNATURE

EastTrust Bank, Nashville
Nashville, Tennessee 37250

⑈0050156 9⑈ ⑆084000046⑆ 702139030 2⑈

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Toll-Free 800-831-4914 Phone (615) 859-0131

SMW+ PROGRAM

EXPLANATION OF BENEFITS

FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
07/17/2002	07/17/2002	872.36	.00	62.80	62.80	62.80
		872.36	.00	62.80	62.80	62.80

NON-COVERED CODES:

COMMENTS:

PROVIDER: WING MEMORIAL HOSPITAL CORP.
PARTICIPANT SSN: 014-05-3319 DEPENDENT: HOWARD :01
SBS CLAIM NUMBER: 1915857

REDACTED

WILBRAHAM MA 01095

Processed by SOUTHERN BENEFIT ADMINISTRATORS, INC.

SEP - 6 2002

Medicare Summary Notice

MEDICARE+MEDICAID

July 25, 2002

TERRY J RAMSEY
102 S THOMAS AVE
EVANSVILLE IN 47714-1437

SM+ only

CUSTOMER SERVICE INFORMATION

Your Medicare Number REDACTED

If you have questions, write or call:
AdminaStar Federal, Inc.
P.O. Box 6130, Indpls, IN 46206-6130
1-800-622-4792
TDD (866) 284-0881
SEND APPEALS:
P.O. Box 50410, Indpls, IN 46250-0410
VISIT US AT:
8115 Knue Road, Indpls, IN 46250

HELP STOP FRAUD: Do not sell your Medicare number or Medicare Summary Notice.

This is a summary of claims processed from 06/25/2002 through 07/25/2002.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02192910687000						
EMERGENCY ROOM ASSOCIATES, PO BOX 963, EVANSVILLE, IN 47706-0963						
DR. JUDE J PEREZ						
06/19/02	1 Injection for nerve block (64450)	$267.00	$57.51	$46.01	$11.50	
06/19/02	1 Emergency dept visit (99283-25)	175.00	56.11	44.89	11.22	
	Claim Total	$442.00	$113.62	$90.90	$22.72	
Claim number 02178941197000						
SOUTHERN INDIANA IMAGING, P O BOX 138, EVANSVILLE, IN 47701-0138						
Referred by: DR. DAVID W BREWER						
DR. JAMES D MCDANIEL						
06/19/02	1 X-ray exam of finger(s) (73140-26) Professional Charge	$27.00	$6.46	$5.17	$1.29	
Claim number 02186924488000						
WELBORN CLINIC, 421 CHESTNUT ST, EVANSVILLE, IN 47713-1297						
DR. GARY ERDY						
06/11/02	2 Iron dextran (J1750)	$60.32	$35.82	$28.66	$7.16	a
06/11/02	1 Office/outpatient visit, est (99213)	67.00	47.34	37.87	9.47	
	Claim Total	$127.32	$83.16	$66.53	$16.63	

SEP 13 2002

THIS IS NOT A BILL - Keep this notice for your records.

0108593

22060535914

Your Medicare Number: REDACTED

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS (continued)

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02190916434000						
WELBORN CLINIC, 421 CHESTNUT ST, EVANSVILLE, IN 47713-1297						
DR. GARY ERDY						
06/25/02	2 Iron dextran (J1750)	$60.32	$35.82	$28.66	$7.16	a
06/25/02	1 Office/outpatient visit, est (99213)	67.00	47.34	37.87	9.47	
	Claim Total	$127.32	$83.16	$66.53	$16.63	

Notes Section:

a The approved amount is based on a special payment method.

Deductible Information:

You have met the Part B deductible for 2002.

General Information:

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

If you change your address, please contact the Social Security Administration by calling 1-800-772-1213.

Who pays? You pay. Report Medicare fraud by calling 1-800-447-8477. An example of fraud would be claims for Medicare items or services you did not receive. If you have any other questions about your claim, please contact the Medicare contractor telephone number shown on this notice.

SEP 13 2002

22060535914

Medicare Summary Notice

HCFA MEDICARE | MEDICAID

August 22, 2002

TERRY J RAMSEY
102 S THOMAS AVE
EVANSVILLE IN 47714-1437

CUSTOMER SERVICE INFORMATION

Your Medicare Number:

If you have questions, write or call:
AdminaStar Federal, Inc.
P.O. Box 6130, Indpls, IN 46206-6130
1-800-622-4792
TDD (866) 284-0881
SEND APPEALS:
P.O. Box 50410, Indpls, IN 46250-0410
VISIT US AT:
8115 Knue Road, Indpls, IN 46250

HELP STOP FRAUD: Do not sell your Medicare number or Medicare Summary Notice.

This is a summary of claims processed from 07/23/2002 through 08/22/2002.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 02204923843000						
WELBORN CLINIC, 421 CHESTNUT ST, EVANSVILLE, IN 47713-1297						
DR. GARY ERDY						
07/09/02	2 Iron dextran (J1750)	$60.32	$35.82	$28.66	$7.16	a
07/09/02	1 Office/outpatient visit, est (99213)	67.00	47.34	37.87	9.47	
	Claim Total	$127.32	$83.16	$66.53	$16.63	
Claim number 02218922483000						
WELBORN CLINIC, 421 CHESTNUT ST, EVANSVILLE, IN 47713-1297						
DR. GARY ERDY						
07/23/02	1 Injection, sc/im (90782)	$8.50	$3.51	$2.80	$0.71	
07/23/02	2 Iron dextran (J1750)	60.32	35.82	28.66	7.16	a
	Claim Total	$68.82	$39.33	$31.46	$7.87	

Notes Section:

a The approved amount is based on a special payment method.

Deductible Information:

You have met the Part B deductible for 2002.

SEP 13 2002

THIS IS NOT A BILL - Keep this notice for your records.

01111764 2234054R164

CMS Medicare Summary Notice

August 01, 2002

TERRY J. RAMSEY
102 S THOMAS AVE
EVANSVILLE IN 47714-1437

9/19/02

CUSTOMER SERVICE INFORMATION

Your Medicare Number: REDACTED

If you have questions, write or call:
Medicare-AdminaStar Federal, Inc.
Inquiries- PO Box 145482, Cincinnati, OH 45250
Appeals- PO Box 812903, Chicago, IL 60681-2903
LOCATED AT:
8115 Knue Rd., Indianapolis, IN 46250

Toll Free: 1-877-602-2430
TTY/TDD 1-866-284-0881 (For the Hearing and Speech Impaired)

HELP STOP FRAUD: Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.

This is a summary of claims processed on 06/28/2002.

PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Control number 20217800602802						a
St Marys Med Ctr Of Evansvill						
3700 Washington Avenue						
Evansville, IN 47750						
Referred by: Jud J. Perez						
06/19/02	Pharmacy	$37.99	$0.00	$0.00	$0.00	b
	Sterile Supply	4.70	0.00	0.00	0.00	b
	X-ray exam of finger(s) (73140)	91.30	0.00	18.10	18.10	
	Emergency dept visit (99284)	440.40	0.00	49.99	49.99	
	Claim Total	**$574.39**	**$0.00**	**$68.09**	**$68.09**	

Notes Section:

a The amount Medicare paid the provider for this claim is $129.77.

b Payment is included in another service received on the same day.

THIS IS NOT A BILL - Keep this notice for your records.

SEP 13 2002

Employee		
04-2103602	25217241 1	

70

REDACTED

11/02/2005
Date Issued

Amount Paid: $531.64

MEDWAY, MA 02053

REDACTED

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. **3093339**

Check No. **1605648**

Explanation of Benefits

SMW+ Program

Dates of Service From	To	Amount Charged	Non Covered	Charges Allowed	Covered Med Med	Med Med Paid
09/19/2005	09/19/2005	$6,134.82	$0.00	$531.64	$531.64	$531.64
	Total	$6,134.82	$0.00	$531.64	$531.64	$531.64

Comments:

REDACTED

Provider: MILFORD REGIONAL MEDICAL CENT
Participant SSN:
SMG Claim Number: 3093339

Provider address:
MILFORD REGIONAL MEDICAL CEN
14 PROSPECT ST
MILFORD, MA 01757

Processed by *Southern Benefit Administrators, Inc.*

MILFORD REGIONAL MEDICAL
14 PROSPECT ST PO BOX 190
MILFORD MA 01757
5084731190 5084731405

2 REDACTED

3 PATIENT CONTROL NO. 25217241 1 | TYPE OF BILL 131

4 FAX NO.	7 COV D.	8 NC D.	9 C-I D.	10 L-R D.	11
0421036021 091905 091905	0	0			

12 PATIENT NAME | 13 PATIENT ADDRESS

;MEDWAY;MA;02053

14 BIRTHDATE	15 SEX	16 MS	17 ADMIT DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	31
06011933	F	W	091905	06		1	99	01	118237	

32 OCCURRENCE CODE | DATE | 33 OCCURRENCE CODE | DATE | 34 | 35 | 36 | 37

38 | 39 VALUE CODES CODE | AMOUNT | 40 VALUE CODES CODE | AMOUNT | 41 VALUE CODES CODE | AMOUNT

MEDWAY MA
02053

REDACTED

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	PHARMACY		091905	9	47320		
259	PHARMACY		091905	10	9833	9833	
270	M & S SUPPLY		091905	11	199900		
360	OPERATING ROOM	66984RT	091905	1	260100		
636	PHARMACY	J3370	091905	1	494		
001	TOTAL CHARGE				613462	9833	

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
MEDICARE B OUTPATIENT	220090	Y	Y	560318		

57 REDACTED DUE FROM PATIENT 0

58 INSURED'S NAME	59 REL	60 INSURED'S - SSN - HIC - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
;	01	)		A&B

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
	5		

67 PRIN. DIAG. CD.	68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
36614	36616										

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
9			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

B73598 GOODMAN GLEN MD
46944 GOODMAN,GLEN MD
B73598 GOODMAN GLEN MD
46944 GOODMAN,GLEN MD
B

84 REMARKS

CMS-1450 (UB-92) OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

220090 | 09/30/2005 | 20051010 PAGE 6

PATIENT NAME / ICN NUMBER / CLAIM #/CLM STATUS / NAME CHG=xx	PATIENT CNTRL NUMBER / HIC NUMBER / MEDICAL REC NUMBER / HIC CHG=x TOB=xxx	FRM DT / THR DT / PAT ST / CV LN	COST / COVDV / NCVD/DENIED / NCVDV / CLAIM ADJS / COVD CHGS	RPTD CHGS / DRG NBR / DRG AMOUNT / DRG O-C	OUTLIER AMT / DEDUCTIBLES / COINS AMT / MSP LIAB MET	REIMB RATE / MSP PRI PAY / PROF COMP / ESRD AMT	ALLOW/REIM / PROC CD AMT / LINE ADJ AMT / CONT ADJ AMT	INTEREST / PAT REFUND / PERDIEM AMT / NET. REIMB
[redacted]		050917	0	1217.32	0.00	0.310	281.48	0.00
		050917	0	1.32	0.00	0.00	62.34	0.00
54 19	199418		0	0.00	0.00	79.17	855.35	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	1216.00		0.00	0.00	281.48
[redacted]		050919	0	507.00	0.00	0.310	54.33	0.00
		050919	0	0.00	0.00	0.00	54.33	0.00
55 1	271236		0	0.00	0.00	0.00	452.67	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	507.00		0.00	0.00	54.33
[redacted]		050829	0	451.00	0.00	0.310	72.21	0.00
		050829	0	0.00	0.00	0.00	46.28	0.00
56 19	108625		0	0.00	0.00	38.04	340.75	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	451.00		0.00	0.00	72.21
[redacted]		050919	0	944.00	0.00	0.310	80.37	0.00
		050919	0	0.00	0.00	0.00	25.69	0.00
57 19	168828		0	0.00	0.00	44.73	818.90	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	944.00		0.00	0.00	80.37
[redacted]		050919	0	62.00	0.00	0.310	17.04	0.00
		050919	0	0.00	0.00	0.00	17.04	0.00
58 1	164905		0	0.00	0.00	0.00	44.96	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	62.00		0.00	0.00	17.04
[redacted]		050916	0	506.00	0.00	0.310	55.14	0.00
		050916	0	0.00	0.00	0.00	55.14	0.00
59 1	113082		0	0.00	0.00	0.00	450.86	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	506.00		0.00	0.00	55.14
[redacted]		050917	0	3335.46	0.00	0.310	477.12	0.00
		050917	0	0.00	0.00	0.00	30.12	0.00
60 1	174913		0	0.00	0.00	265.57	2592.77	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	3335.46		0.00	0.00	477.12
[redacted]		050919	0	440.00	0.00	0.310	57.90	0.00
		050919	0	0.00	0.00	0.00	57.90	0.00
61 1	195913		0	0.00	0.00	0.00	382.10	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	440.00		0.00	0.00	57.90
[redacted]		050919	0	259.54	0.00	0.310	61.75	0.00
		050919	0	1.54	0.00	0.00	0.00	0.00
62 19	116397		0	0.00	0.00	20.98	175.27	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	258.00		0.00	0.00	61.75
		050919	0	6134.82	0.00	0.310	893.48	0.00
		050919	0	98.33	0.00	0.00	0.00	0.00
63 1	118237		0	0.00	0.00	531.64	4611.37	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	6036.49		0.00	0.00	893.48
[redacted]		050920	0	178.00	0.00	0.310	14.79	0.00
		050920	0	0.00	0.00	0.00	14.79	0.00
64 1	208279		0	0.00	0.00	0.00	163.21	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	178.00		0.00	0.00	14.79
[redacted]		050919	0	428.00	0.00	0.310	28.63	0.00
		050919	0	0.00	0.00	0.00	28.63	0.00
65 1	210302		0	0.00	0.00	0.00	399.37	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	428.00		0.00	0.00	28.63
[redacted]		050916	0	45.00	0.00	0.310	7.16	0.00
		050916	0	0.00	0.00	0.00	7.16	0.00
66 1	140279		0	0.00	0.00	0.00	37.84	0.31
NAME CHG=QC	HIC CHG=HN TOB=131		0	45.00		0.00	0.00	7.16

REPLACED